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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 92-1964
CA-91-736

STUART CIRCLE HOSPITAL CORPORATION
Plaintiff-Appellant

v.

AETNA HEALTH MANAGEMENT; AETNA LIFE INSURANCE COMPANY
Defendants-Appellees

HCA HEALTH SERVICES OF VIRGINIA
Amicus Curiae

FILED
July 1, 1993

On Petition for Rehearing with Suggestion for Rehearing In Banc

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The appellees' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Bert M. Montague
CLERK

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 92-1964

STUART CIRCLE HOSPITAL CORPORATION,
Plaintiff-Appellant,

v.

AETNA HEALTH MANAGEMENT; AETNA LIFE INSURANCE COMPANY,
Defendants-Appellees.

HCA HEALTH SERVICES OF VIRGINIA,
Amicus Curiae.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Richard L. Williams, Senior District Judge. (CA-91-736)

Argued: March 2, 1993

Decided: June 2, 1993

Before BUTZNER, Senior Circuit Judge. VOORHEES, Chief United States District Judge for the Western District of North Carolina, sitting by designation, and SPENCER, United States District Judge for the Eastern District of Virginia, sitting by designation.

Vacated and remanded by published opinion. Senior Judge Butzner wrote the opinion, in which Chief Judge Voorhees and Judge Spencer joined.

COUNSEL

ARGUED: Peter B. Edelman, KECK, MAHIN & CATE, Washington, D.C., for Appellant. William Jeffrey Kilberg, GIBSON, DUNN & CRUTCHER, Washington, D.C., for Appellees. **ON BRIEF:** Philip L. O'Neill, KECK, MAHIN & CATE, Washington, D.C., William R. Rakes, J. Scott Sexton, GENTRY, LOCKE, RAKES & MOORE, Roanoke, Virginia, for Appellant. Paul Blankenstein, Jeffrey T. Gilleran, GIBSON, DUNN & CRUTCHER, Washington, D.C.; John B. McCammon, Laura G. Fox, WRIGHT, ROBINSON, MCCAMMON, OSTHIMER & TATUM, Richmond, Virginia, for Appellees. William D. Iverson, William J. Shieber, COVINGTON & BURLING, Washingtgon, D.C., for Amicus Curiae.

OPINION

BUTZNER, Senior Circuit Judge:

Stuart Circle Hospital Corporation appeals the district court's grant of summary judgment against it and in favor of Aetna Health Management and Aetna Life Insurance. *See Stuart Circle Hospital Corp. v. Aetna Health Management*, 800 F. Supp. 328 (E.D. Va. 1992). The Hospital alleges that the district court erred by holding that Virginia Code § 38.2-3407, which prohibits insurance companies from unreasonably discriminating in establishing preferred provider organizations (PPOs), is unenforceable because it is preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a). We review the district court's decision de novo. *Higgins v. E.I. DuPont*, 863 F.2d 1162, 1167 (4th Cir. 1988). Because we conclude that ERISA's insurance savings clause, 28 U.S.C. § 1144(b)(2)(A), exempts the Virginia statute from the application of ERISA's preemption clause, we vacate the judgment of the district court and remand the case for further proceedings.

I

To establish an insurer's PPO, an insurance company contracts with hospitals, doctors, and other health care providers for reduced charges. The insurer encourages utilization of these providers by its insureds. Although insureds may use providers other than those which participate in the PPO, they generally must pay a higher fee for the service rendered, as well as be reimbursed at a lower rate.

Virginia regulates the selection of an insurance company's preferred providers by Virginia Code § 38.2-3407:

> A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.
>
> B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded.
>
> * * *
>
> E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

This section is one of several statutes found in chapter 34 of the Virginia Code, §§ 38.2-3400 to 38.2-3430, relating to accident and sickness insurance.

In early 1987, Aetna established a PPO in Richmond. Aetna markets its PPO only to employee benefit plans. The hospitals which Aetna selected as providers for its PPO were the same hospitals that were already participating in Aetna's health maintenance organization, HMO CHOICE. Aetna did not designate Stuart Circle Hospital to be one of its PPO provider facilities, although Stuart Circle was willing to meet Aetna's terms.

The Hospital brought this action, alleging that Aetna had failed to comply with Va. Code § 38.2-3407 by excluding it from participation in the Aetna PPO. In its defense, Aetna asserted that the Virginia statute is preempted by ERISA. The district court found that the Virginia statute affects employee benefit plans by regulating the structure of an insurer's PPO. 800 F. Supp. at 331-32. It therefore decided that because the Virginia statute relates to employee benefit plans, ERISA preempts the statute unless it is saved from preemption by the insurance clause. 800 F. Supp. at 333. Concluding that the Virginia statute regulated the business of an insurance company, and not the business of insurance, the district court held that ERISA preempted it. 800 F. Supp. at 333-37. The court granted summary judgment for Aetna, and Stuart Circle appealed.

II

Title 29 U.S.C. § 1144(a) provides that ERISA preempts state laws that "relate to any employee benefit plan," unless the laws are exempted. From time to time the Supreme Court has emphasized the breadth of ERISA's preemption provision. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-42 (1990) (citing cases). It has stated that the "relates to" language should be given its broad

common-sense meaning so as to displace state laws which even indirectly concern themselves with employee benefits plans. Pointing out that "the key to [ERISA's preemption clause] is found in the words 'relate to,' " the Court reiterated that a state law may be preempted even though it does not address "the specific subjects covered by ERISA." *Ingersoll-Rand,* 498 U.S. at 138. The Court has delineated the breadth of the preemption clause by the statement: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). It is not surprising, therefore, that the Court has "virtually taken it for granted that state laws which are specifically designed to affect employee benefit plans are preempted. . . ." *Mackey v. Lanier Collection Agency,* 486 U.S. 825, 829 (1988) (citations and internal quotation marks omitted).

We agree with the district court that, contrary to the Hospital's contentions, Va. Code § 38.2-3407 relates to employee benefit plans.

The Virginia statute states that it applies to "health benefit program[s]" operated by insurers. Additionally, it has at its core a provision relating to the benefits which an insured may receive from an insurer's PPO. The statute restricts the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit health plan to those preferred by the insurer. To be sure, a participant can select a provider outside the plan, but only at the expense of forfeiting some of his or her benefits. We conclude that 29 U.S.C. § 1144(a) preempts Va. Code § 38.2-3407 unless ERISA's insurance savings clause applies.

III

ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), provides that "nothing in this subchapter

shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." The effect of the clause is to save state laws governing the business of insurance from preemption that would otherwise occur by application of 29 U.S.C. § 1144(a). The Hospital argues that this savings clause exempts Va. Code § 38.2-3407 from ERISA preemption because the Virginia statute regulates the business of insurance. Aetna contends, and the district court held, that the Virginia statute is not saved from preemption because it regulates the non-insurance business of insurance companies.

In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), the Supreme Court addressed the savings clause in the context of determining whether a state statute which mandated a minimum level of psychological benefits regulated insurance and was thus saved from ERISA preemption. The Court approached its task by employing a two-part analysis. First, the Court took a "common-sense" approach, finding that the statute at issue regulated insurance contracts and thus logically should be encompassed by the "which regulates insurance" language of the savings clause. *Metropolitan Life,* 471 U.S. at 740-41. Second, the Court examined the case law which interpreted the phrase "business of insurance" with respect to the McCarran-Ferguson Act, 15 U.S.C. § 1011 et. seq. To illustrate that Massachusetts' mandated benefit law was a regulation of the business of insurance and, therefore, not preempted by ERISA, the Court reiterated:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policy-

> holder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

Metropolitan Life, 471 U.S. at 743-44 (emphasis deleted) (*quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)).

The Court also referred to criteria for interpreting the scope of the McCarran-Ferguson Act set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982):

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Metropolitan LIfe, 471 U.S. at 743.

Applying these standards, we conclude that Va. Code § 38.2-3407 regulates the business of insurance. It is part of a comprehensive code regulating accident and sickness insurance. The statute regulates the "relationship between insurer and insured [and] the type of policy which could be issued." 471 U.S. at 744. It prohibits an insurer's unreasonable restriction of the insured's choice of physician and hospital. To borrow the Court's phrase, a "commonsense view" of the Virginia statute discloses that it regulates certain insurance contracts, albeit indirectly through the structure of the PPO.

Furthermore, the Virginia statute passes muster under the three criteria that *Metropolitan Life*, 471 U.S. at 743, derived from *Pireno*. As *Pireno* notes: "None of these criteria is necessarily determinative in itself. . . ." 485 U.S. at 129. The Virginia statute satisfies the first criterion, "transferring or spreading the policyholder's risk." There are several components to the "policyholder's risk." They include the types of illness and injury that the insurance

contract covers, provision for treatment, and the cost of treatment. The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

The Virginia statute satisfies the second criterion because it is "an integral part of the policy relationship between the insurer and the insured." *Metropolitan Life,* 471 U.S. at 743. We repeat, treatment and cost are important components of health insurance. Regulations governing these components, such as the Virginia statute, are integral parts of the relationship between insurer and insured. In this respect mandatory-provider regulations are conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance and consequently not preempted by ERISA. 471 U.S. at 758. Moreover, in dicta, speaking of state regulation of the substantive terms of group health insurance contracts, the Court recognized that mandatory-provider statutes were among these terms in many states. *See Metropolitan Life,* 471 U.S. at 729 and n.9.

The Virginia statute also satisfies the third criterion. It is expressly "limited to entities within the insurance industry." *Metropolitan Life,* 471 U.S. at 743. ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), precludes employer self-funded employee benefits plans from being brought within the scope of Va. Code § 38.2-3407. The district court

observed that this difference in the regulation of employer-funded PPOs and insurer PPOs creates an anomalous situation. 800 F. Supp. at 336. But this anomaly does not counsel preemption. The Supreme Court referred to a similar situation in *Metropolitan Life*:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747.

Though the Virginia statute regulates the relationship between the insurer and insured through the formation of the insurer's PPO, it is nonetheless a law regulating the business of insurance. The Supreme Court held in *SEC v. National Securities*, 393 U.S. at 460, and reiterated in *Metropolitan Life*, 471 U.S. at 744, that statutes regulating the relationship between insurer and insured "directly or indirectly are laws regulating the business of insurance."

Aetna relies primarily on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), for the proposition that Va. Code § 38.2-3407 does not regulate the business of insurance within the meaning of the McCarran-Ferguson Act. *Royal Drug* concerned an antitrust challenge by several pharmacists to an insurance company's program requiring any pharmacy which desired to serve the company's policyholders to sell them prescription drugs for $2 and to seek reimbursement from the insurer for only the cost of acquiring the drugs. The Court held that these agreements were "merely arrangements for the purchase of goods and services" by the insurance company. 440 U.S. at 214. Consequently, it ruled that the program was not the business of insurance within the meaning of the McCarran-Ferguson Act and that it was not exempted from

antitrust laws. 440 U.S. at 214. To the same effect is *General Motors Corp. v. Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986), which relied on *Royal Drug* to preempt a statute dealing with a prescription drug program.

Aetna analogizes the Virginia statute to the drug purchase program described n *Royal Drug*. It characterizes the PPO regulation as merely facilitating the exchange of goods and services and thus not transferring or spreading risks. It emphasizes the fact that the regulation affects only the relationship between insurers and providers, not between insurers and insureds.

The practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits to insureds because any pharmacy which agreed to the insurance company's terms was allowed to participate. Aetna's characterization of the Virginia statute misconceives the relationship which the Virginia statute affects. As previously explained, although facially the statute only directly affects providers, it indirectly affects the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.

Aetna's claim that its PPO is simply a commercial transaction that reduces the cost of insurance overlooks the decision of the Virginia General Assembly to give priority to an insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums. This legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary.

Although the Court cited *Royal Drug* in *Metropolitan Life*, 471 U.S. at 743, it did not consider the outcome of *Royal Drug* to be precedent applicable to a statute prescribing mandatory benefits in health insurance contracts. Following the rationale of *Metropolitan Life*, we believe

that *Royal Drug* is not precedent applicable to the Virginia statute pertaining to mandatory providers in insurers' PPOs.

Other courts support our conclusion that because the Virginia statute regulates the business of insurance, ERISA does not preempt it. In *Blue Cross and Blue Shield v. St. Mary's Hospital*, ___ Va. ___ , 426 S.E.2d 117 (1993), the Supreme Court of Virginia relied on *Metropolitan Life*, 471 U.S. 724, to hold that a statute regulating non-stock insurance company PPOs regulated the business of insurance and thus escaped preemption by ERISA. In that case the issues were the same as those before us. A hospital excluded from a PPO sought redress. The Virginia Supreme Court noted the district court's opinion in *Stuart Circle*, which we are reviewing, and declined to follow it.

Reaching the same conclusion with respect to statutes mandating specialized providers are *Blue Cross and Blue Shield v. Bell*, 798 F.2d 1331, 1334-36 (10th Cir. 1986), and *Blue Cross Hospital Service v. Frappier*, 698 S.W.2d 326 (Mo. 1985).

The district court's judgment is vacated, and the case is remanded for further proceedings. The Hospital shall recover its costs.

VACATED AND REMANDED

APPENDIX C

IN THE
UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA
Richmond Division

File No. 91-736

STUART CIRCLE HOSPITAL CORP.,
Plaintiff,

v.

AETNA HEALTH MANAGEMENT, *et al*,
Defendants.

FILED
JULY 22, 1992

MEMORANDUM OPINION

This matter is before the Court on the Defendant's Motion for Summary Judgment pursuant to Fed. R. Civ. P. 56. For the reasons stated below, the Defendant's motion is granted and the case is hereby dismissed with prejudice.

BACKGROUND

Stuart Circle Hospital Corporation ("Stuart Circle") seeks a judgment against the Defendants Aetna Life Insurance Co. and Aetna Health Management (collectively "Aetna") declaring that Aetna's actions in implementing and operating a preferred provider organization (the "Aetna PPO") are in violation of Va. Code § 38.2-3407 (the "PPO Statute") and enjoining further violations or operations until the Aetna PPO) is established in compliance with the PPO Statute.

Defendant Aetna variously administers and insures employee benefit plans in Virginia. Among the various products that Aetna offers its employee benefit plan customers in the Richmond area is a Preferred Provider Program, the main feature of which is the Aetna PPO. Aetna offers the Preferred Provider Program only to employee benefit plans.

The Aetna PPO in the Richmond area was originally established by Aetna in 1987, and is now managed by Aetna Health Management ("AHM"). AHM maintains the Aetna PPO through contracts with selected health care providers who agree (1) to provide services at discounts from their normal fees to individuals covered under employee benefit plans administered or insured by Aetna; and (2) to comply with the utilization review requirements of the employee benefit plans. In return, these providers expect an increase in patient volume because the employee benefit plans are designed to provide financial incentives for plan participants to select the preferred provider. AHM currently has preferred provider contracts with six Richmond area hospitals: Retreat, Richmond Memorial, St. Mary's, Henrico Doctors', Chippenham, and Johnston-Willis.

Currently, over 120 Richmond area employee benefit plans utilize Aetna's Preferred Provider Program. Some of these plans are self-insured, in which case Aetna acts as administrator of the employee benefit plan. In other cases, Aetna acts as both insurer and administrator of the employee benefit plan. However, the offers and negotiations between Aetna and the hospitals selected for the PPO did not involve any employee benefit plan, employer, or sponsor of an employee benefit plan. Rather, Aetna and the hospitals were the sole contracting parties in the process.

Stuart Circle claims that is was unreasonably excluded from the Aetna PPO, not because it could not meet Aet-

na's "terms and conditions," but because it was not a member of Aetna's HMO in Richmond. Stuart Circle demands that Aetna comply with the requirements of Virginia law governing the establishment of a PPO by an insurer.

Prior to determining the merits of the case, the Court required the parties to brief the issue of whether Plaintiff's claim may be preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*. *See HCA Health Services v. Metropolitan Life Ins. Co.*, No. 91-2606 (4th Cir. Feb. 24, 1992) (slip op. at 8 n.1) ("The District Court erred in interpreting the Virginia statute before deciding if it was preempted by ERISA.").

ISSUE

This dispute involves the application and interpretation of Va. Code Ann. § 38.2-3407(B). The question presented is whether this provision is preempted by ERISA. To resolve this question, the Court must determine (1) whether § 38.2-3407(B) "relates to" employee benefit plans and thus comes under the purview of ERISA and (2) whether Virginia's PPO statute regulates the "business of insurance" as this term has been defined under the McCarran-Ferguson Act and thus comes within ERISA's "savings clause."

DISCUSSION OF AUTHORITY

The Plaintiff argues that Va. Code § 38.2-3407(B) does not "relate to" an employee benefit plan, and even if it did, it regulates insurance and, therefore, is saved from preemption by ERISA. The Defendant argues the very opposite—that the Virginia statute is preempted by ERISA but does not regulate the "business of insurance."

I. THE PPO STATUTE

The PPO Statute, Section 38.2-3407, provides as follows:

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers based on market conditions or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

II. PREEMPTION UNDER ERISA

An employee welfare plan is defined under ERISA as a plan which provides to employees "medical, surgicial, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance—so-called "insured plans"— are directly affected by state laws that regulate the insurance industry.

ERISA imposes a variety of substantive requirements relating to participation, funding, and vesting upon welfare

plans, but does not regulate the substantive content of such plans. Thus, ERISA contains almost no federal regulation of the terms of benefit plans. It does, however, contain a broad preemption provision:

> Except as provided in subsection (b) of this section (the savings clause), the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

ERISA § 514(a), 29 U.S.C. § 1144(a). Thus, any state law that "relate[s] to" an "employee benefit plan" is preempted,[1] unless it fits within one of the enumerated categories of permissible state regulation.

The United States Supreme Court has interpreted ERISA § 514(a) quite broadly. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). It has repeatedly recognized that the words "relate to . . . express a broad preemptive purpose." *Morales v. Trans World Airlines*, No. 90-1604 (U.S. June 1, 1992) (Slip op. at 7.).

A state law law "relate[s] to" an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (holding that the New York Human Rights Law prohibiting employers from structuring employee benefit plans in a manner which discriminates on the basis of pregnancy relates to employee benefit plans and is, therefore, preempted by ERISA). Preemption is, moreover, not limited to "state laws specifically designed to affect employee benefit plans," nor is it limited to state laws that relate to subject matters addressed by ERISA. *Id.* at 98-99.[2] Even laws that have

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[1] "The Supremacy Clause of Article VI of the Constitution provides Congress with the power to pre-empt state law." *Louisiana Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 368 (1986).

[2] Of course, § 514(a) preempts state laws only insofar as they relate to plans covered by ERISA.

only indirect effects on private employee benefit plans are preempted if they "relate" to such a plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Examination of Virginia Code § 38.2-3407 in light of these governing principles compels the conclusion that it is a law that "relate[s] to" employee benefit plans. By contrast, in arguing that the PPO Statute does not relate to employee benefit plans, the Plaintiff stresses that the provision "does not directly regulate the content of an employee benefit plan," and that "[t]he existence of an employee benefit plan is not central to or determinative with respect to the application" of the PPO Statute. (Pl. Mem. at 10.) Plaintiff then tries to minimize the statute's effect on employee benefit plans by describing the effect as "incidental" or "derivative." (Pl. Mem. at 5, 10, 11, 15, and 17) These points are not well taken.

Plaintiff's narrow reading of section 514(a) of ERISA ignores controlling precedent and is at odds with the purpose behind ERISA preemption. The Supreme Court specifically rejected an interpretation of "relate[s] to" that would have limited section 514(a) to "state laws specifically designed to affect employee benefit plans," *Shaw*, 463 U.S. at 98, and has held that even indirect state action bearing on pensions may encroach upon the area of exclusive federal concern. *Alessi*, 451 U.S. at 525. So long as a state law has a "connection with or reference to" an employee benefit plan, then the law relates to the plan, and it is of no consequence whether the effect on the plan is direct or indirect.[3]

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[3] The Court rejects the Plaintiff's contention that the Second Circuit's opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), requires a conclusion that the PPO Statute does not relate to employee benefit plans. In *Rebaldo*, the Court found that ERISA did not preempt a New York statute setting certain prices for certain hospital services for all purchasers of such services. The court concluded that the New York statute, which effectively prevented em-

Virginia's PPO Statute does have a clear connection to and effect on employee benefit plans. First, on its face, the statute states that an insurer may offer or administer a "health benefit program." This language appears to clearly contemplate employee benefit plans. Moreover, the chapter of the Virginia Code that includes section 38.2-3407 applies to *group* accident and sickness policies. *See* Va. Code §§ 38.2-3400(A), 38.2-109, and 38.2-3401. ERISA plans are, of course, group plans. *See* 29 U.S.C. § 1002(a).

Secondly, even though the PPO Statute does not directly regulate employee benefit plans, the statute affects those plans in such a manner as to fit within ERISA's preemptive reach. Section 38.2-3407 goes to the sum and substance of employee benefit plans: the delivery of promised benefits. *See General Motors Corp. v. Caldwell*, 647 F.Supp. 585, 587 (N.D. Ga. 1986) (statute regulating establishment of participating pharmacy agreements "strikes at the heart of a feature of employee benefit plans"). The reason why Stuart Circle wants to be included in Aetna's PPO is pre-

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ployee benefit plans from negotiating a reduced rate with hospitals, did not "relate to" employee benefit plans simply because it increased the plan's cost of doing business and because it increased the plan's cost of doing business and because it did "not affect the structure, adminstration or the type of benefits provided by an ERISA plan." *Id.* at 139.

However, unlike the New York statute in *Rebaldo*, whose sole relation to employee benefit plans was to increase the cost of doing business, the PPO Statute before the Court today does not simply increase the cost of doing business for employee benefit plan administrators. Virginia's PPO Statute would also affect the structure, administration, and the type of benefits provided by the plans. Moreover, *Rebaldo* pre-dates the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), in which the Court reiterated that even indirect impact on an employee benefit plan brings a state statute within the scope of ERISA preemption. And in fact, the Second Circuit itself has questioned the continuing vitality of *Rebaldo*. *See Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n.3. (2d Cir. 1992).

cisely so it can gain entree into the lucrative business of supplying health care to employee benefit plans. Preferred provider arrangements, the target of the statute, are creatures of employee benefit plans. They are the principal means by which employee benefit plans deliver their promised medical benefits; as such, regulation of the structure of the PPO network necessarily affects the benefit plans and thus "relate[s] to" them.

By regulating the makeup of the PPO networks, the PPO Statute constrains how health benefits may be structured under an employee benefit plan and interferes with the discretion of the plan sponsor. Under the PPO Statute, an employee benefit plan which is insured or which chooses an insurer to administer the plan will have to include providers as preferred providers who would not otherwise be included. Thus, the statute prohibits effective limitation of the hospital provider network, and a critical cost containment feature of the employee benefit plans subscribing to Aetna's Preferred Provider Program is greatly diminished.[4]

The administration of the employee benefit plans is similarly affected. Whether a provider is "preferred" will affect the formula for benefit payments by employee benefit plans with respect to services rendered by that provider to plan participants. Through its contract with the Aetna PPO, the provider becomes directly "connected with" employee benefit plans administered or insured by Aetna. That a provider is "preferred" changes both the manner and amount of benefits paid by the employee benefit plan.

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[4] As this Court found in *HCA Health Services v. Metropolitan Life Ins. Co.*, "[t]he exclusion of some providers is a necessary prerequisite of a limited provider network. It is by limiting the number and types of providers included in a PPO that an insurer is able to implement cost reductions in services for health beneficiaries." C.A.90-285-R, slip op. at 3 (E.D. Va. Dec. 7, 1990).

The connection or effect that the PPO Statute has on employee benefit plans can be easily illustrated. Imagine Employee Benefit Plan X organizes a PPO network with four Richmond area health care providers. Not included in this list, for reasons peculiar to Plan X, is Stuart Circle Hospital. Plan X secures a 15% discount on all services for its beneficiaries. This discount is offered because the included hospitals expect that the beneficiaries of Plan X will have a great incentive to choose one of the network hospitals for their health care needs. Plan X's participants may go to another provider, but they will have to pay the difference in costs out of their own pockets. To administer this PPO, Employee Benefit Plan X hires Aetna, an insurance company. Under the mandate of Va. Code § 38.2-3407, if a district court has to order that Stuart Circle Hospital and other comparable health care providers must be included in the limited network, then clearly Plan X's benefit scheme will be effected. For instance, the original providers may determine to provide only 10% discounts or may impose other conditions. The end result is that the system carefully constructed by Plan X will be changed. For this reason, Virginia's PPO Statute, in both purpose and effect, "relate[s] to" employee benefit plans.

Indeed, a number of courts have recognized that state statutes regulating preferred provider arrangements necessarily relate to employee benefit plans. For instance, in *General Motors Corp. v. Cladwell*, 647 F.Supp. 585 (N.D. Ga. 1986), the Georgia statute at issue, like the Virginia statute here, required that all providers (pharmacies) willing to meet the terms of inclusion be entitled to become participating pharmacies. Ga. Code Ann. § 26-4-144(a). The court in *Caldwell* concluded that the Georgia law "clearly has an indirect but substantial relation to [employee benefit plans]" because it "regulates the discount features currently provided to plan beneficiaries" and creates an administrative scheme with which plan administrators have to comply. *Caldwell*, 647 F. Supp. at 587. The court noted

that "although the Act is not specifically denominated as a statute regulating employee benefit plans, it clearly targets them." *Id.; see also Blue Cross & Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1276 (N.D. Ala. 1983) (holding in a similar case that "[a]lthough the Act directly regulates the agreements and relationships *between insurers and pharmacies*, it effectively regulates what employers and employees can and cannot include in employee benefit plans." (emphasis added)). The same can be said about Virginia's PPO Statute.

Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield, 708 F. Supp. 826 (E.D. Mich. 1989), is also instructive. There, providers of mental health care services brought suit against Blue Cross alleging that a program offered by General Motors to certain employees, which required preauthorization of mental health care services, violated certain state laws. The participating mental health care providers had contracted with Blue Cross, as the administrator of the General Motors plan, to render services to persons covered under the program in accordance with the program's managed care requirements, and to accept reimbursement for services rendered in accordance with the program's fee schedules.

The *Adnan Varol* Court held that the state law claims were preempted by ERISA because they went directly to the essence of the employee benefit plan—the preauthorization and managed care requirements—even though the contracts at issue were between Blue Cross and the providers. "[T]he provider contracts between plaintiffs and [Blue Cross] are merely the means for carrying out the benefit plan agreed to between GM and the U.A.W." *Id.* at 832. Similarly, in this case, Stuart Circle seeks to become a party to a preferred provider contract offered by Aetna. However, as the *Adnan Varol* Court notes, these contracts are merely the means for carrying out the employee benefit plans that utilize the Aetna PPO.

In short, the PPO Statute, Va. Code § 38.2-3407, "relate[s] to" employee benefit plans and is preempted under ERISA § 514(a) unless it is saved from preemption by one of the exceptions listed in ERISA § 514(b), 29 U.S.C. § 1144(b).

III. THE SAVINGS CLAUSE AND THE "BUSINESS OF INSURANCE"

State laws regulating insurance are "saved" from preemption by ERISA § 514(b) (2) (A) which provides:

> Except as provided in subparagraph (B) (the deemer clause), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b) (2) (A).

Whether a state law "regulates insurance" for purposes of ERISA is analyzed in accordance with the principles that have been developed under the McCarran-Ferguson Act.[5] The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, provides in part:

> No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), the Supreme Court identified three factors for determining whether a practice is the "business of insurance" for purposes of the McCarran-Ferguson Act:

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[5] In *Metropolitan Life*, the Supreme Court recognized that the ERISA savings clause and the McCarran-Ferguson Act "serve the same federal policy and utilize similar language to define what is left to the States." 471 U.S. at 744 n.21.

> [*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

The Plaintiffs maintain that the PPO Statute at issue does not regulate the "business of insurance" under the three factor test of *Pireno*. First, the Plaintiff argues that the application of § 38.2-3407 operates to spread risk because if affects the type of coverage that must be provided pursuant to a preferred provider program established by an insurer. The prohibition against unreasonable discrimination in the terms and conditions governing provider participation is closely related to the scope of coverage mandated and the availability of services. As such, the Virginia statute regulates who can provide the covered services and how the health care provider is selected. The risk affected, therefore, is the cost of health care to be borne by the insurer or the beneficiary of the insurance program. Aetna offers the PPO in connection with its insurance products. The Plaintiff claims that the nexus between Aetna's insurance products and its PPO is sufficient to link the PPO to Aetna's insurance with respect to the transfer of risk.

The Plaintiff relies on the case of *Blue Cross and Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986), in which the court ruled that Kansas statutes imposing mandated benefits and mandated provider requirements on health insurance policies were not preempted by ERISA because of the insurance savings clause. With respect to the first element of the McCarran-Ferguson test, the court stated:

> Insurance is an arrangement for transferring and distributing risk . . . . [T]he insured's right to choose the type of practitioner to fulfill the agreed upon coverage must figure into, and play a part in, the 'spreading

> and underwriting of a policyholder's risk.' (Citations omitted.) . . . Implicit in the coverage of [health] care is the insured's choice of a deliverer of the care. The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk. Thus, the mandated provider statutes at issue satisfy the first criterion of the 'business of insurance.'

Bell, 798 F.2d at 1335.

Secondly, the Plaintiff argues that the PPO statute affects the policy relationship between the insurer and the insured. The statute affects the establishment of the service delivery mechanism, the types of providers that must be included, and preserves access to nonpreferred providers. All this affects the nature of the services available, who can provide those services, and who must be paid for those services. The Plaintiff argues that each of these factors is intimately related to the policy relationship.

Again, the Plaintiff relies on *Bell* with respect to the second element of the test:

> The second criterion is readily met. The selection of a particular provider is as integral to the bargained-for coverage as the coverage itself. The freedom to choose a treating physician is inextricable from the nature of the coverage provided. Because the policy alone has defined the limits of coverage, the insured's choice of a provider resides with the contractual relationship between the insurer and the insured. (Citation omitted.)

Id. at 1335.

Lastly, the Plaintiff argues that the ERISA savings clause applies because the PPO Statute is imposed solely on insurers. Section 38.2-3407 is a portion of Virginia's Insurance Code and its provisions apply solely to "insur-

ers" as defined in section 38.2-100. None of Plaintiff's arguments are persuasive.

As the Defendant correctly argues, the PPO statute in question does not regulate the "business of insurance," but, instead regulates the "business of insurance companies." While the former is saved from ERISA preemption, the latter is not. Applying the *Pireno* test, first, the agreements entered into between Aetna and various health care providers do not involve the spreading of risk. Unlike Stuart Circle, Aetna argues that its PPO is, in actuality, a cost saving arrangement, not a risk transferring mechanism, even if the cost-savings translate into lower premiums for the insured. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 216 (1979).

For example, in *Royal Drug*, a Texas insurance company offered policies entitling insured persons to purchase prescription drugs for $2 each from any pharmacy participating in a "Pharmacy Agreement" with Blue Shield; policyholders could also purchase prescription drugs from nonparticipating pharmacies but would have to pay the full price and seek reimbursement from Blue Shield for a portion of the price. Any Texas pharmacy could participate, although the pharmacy was required by the plan to sell prescription drugs to Blue Shield's policyholders for $2 each, and were only remebursed for the costs of acquiring the drugs.

In analyzing these pharmacy agreements to determine if they qualified as the "business of insurance," the Supreme Court first noted that the agreements did not have the effect of transferring or spreading a policyholder's risk because they were "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214. The agreements served "only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations, *id.* at 213, and while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure

ultimately to the benefit of policyholders in the form of lower premiums, . . . they are not the 'business of insurance.' " *Id.* at 214.

The arrangements between Aetna and the hospitals and physicians that participate in the Aetna PPO are similarly "for the purchase of goods and services," not involving the business of insurance.[6] Aetna contracts with various hospitals and physicians to provide health care to Aetna's customers, who may or may not be insured by Aetna.[7] Any transfer of risk occurs when (and if) Aetna insures a benefit plan, not when it minimizes its cost of fulfilling its contractual obligations. Thus, the arrangements are "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keep low the level of premiums charged to their policyholders." *Id.* at 215.

Secondly, the practice is not an integral part of the relationship between the insurer and the insured. Indeed, in many instances there is no insurer-insured relationship between Aetna and the employee benefit plan. As in *Royal Drug*, the agreements at issue are not between the insurer and the insured but, rather, between Aetna and hospitals/physicians. *See also Caldwell*, 647 F. Supp. at 589 ("As

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[6] *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939), specifically relied on by the Supreme Court in *Royal Drug*, supports the Defendant's argument. In *Jordan*, the D.C. Circuit held that an arrangement between a corporation that contracted with physicians, hospitals, and others to provide medical services did not constitute the business of insurance. *Id.* at 247. Rather, the court concluded that the corporation's activities "constitute the quantity purchase of well-rounded, continuous medical service by its members." *Id.* Unlike the business of insurance which is principally concerned with risk, the corporation was "concerned principally with *getting services rendered* to its members and doing so at lower prices made possible by quantity purchasing and economics in operation." *Id.* (emphasis in original).

[7] Recall that Aetna sells access to its PPO as a thrid party administrator for self-funded plans.

the agreements are with parties outside the insurance industry, they do not meet the second criterion for identifying the 'business of insurance.' ") If the Virginia statute meant to regulate the business of insurance, its aim at the relationship between the insurer and medical providers is off target.

Finally, the practice being regulated is not limited to entities within the insurance industry. Various non-insurers maintain preferred provider programs in Virginia. PPO programs simply constitute a line of business in which Aetna, an insurance company, has entered. *See Caldwell*, 647 F. Supp. at 589 ("provision of prescription drugs through participating agreements is not a practice which is limited to the insurance industry"). Section 38.2-3407 does not regulate insurance contracts; it regulates a type of business entered into by insurance companies. This practice also "inevitably involves third parties wholly outside the insurance industry—namely, [hospitals and physicians]." *Pireno*, 458 U.S. at 132. In addition, the PPO Statute affects insurance companies even if they do not insure the employee benefit plan which has access to the PPO, but simply administer it. Thus, because the practice is one that frequently and inevitably involves entities outside the insurance industry, and sometimes does not even involve insurance at all, it does not meet the third criterion for identifying practices constitution the "business of insurance."

The Plaintiff's reliance on the Tenth Circuit's decision in *Bell* is misplaced. As discussed above, that case involved a Kansas statute that imposed mandated benefits and mandated provider requirements on health insurance policies. *Bell*, 798 F.2d at 1333. Statutes which specify what benefits *must be provided* are clearly distinguishable from the regulation of how those health care benefits are to be delivered, which is the focus of the PPO Statute. Thus, the practice at issue in *Bell* involved the regulation of activities far closer to the business of insurance than the

PPO arrangements entered into between Aetna and the various hospitals and physicians it contracts with to provide medical and health services to its customers.

In sum, the Court finds that the Virginia PPO Statute relates to employee benefit plans. First, this case is more analogous to *Royal Drug* and *Caldwell*, both of which involved participating pharmacy agreements, than it is to *Bell*. Second, taking a "common-sense view of the matter," *see Metropolitan Life*, 471 U.S. at 740, the PPO Statute seeks to regulate businesses that organize PPOs; the statute focuses on the relationship between insurers and those health benefit providers who participate in PPO networks. The statute does not involve the relationship between insurers and policyholders, such as the issuance, reliability, type, or interpretation of insurance contracts—the essence of the business of insurance. *See, e.g., SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Moreover, under the PPO Statute, it is of no consequence whether or not the insurance company regulated is actually insuring any benefit plans at all. If section 38.2-3407 truly regulated the business of insurance, then the action of a non-insurer, say a third-party administrator, in offering a health benefit program containing a PPO should also constitute the business of insurance. This is, of course, not the case. *See FMC Corp. v. Holliday*, 111 S.Ct. 403, 409 (1990);[8] *Thompson v. Talguin Bldg. Products Co.*, 928

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[8] In *FMC Corp.*, the Supreme Court stated:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause .... [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans. State laws directed toward the plans are pre-empted because the relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be

F.2d 649, 652 (4th Cir. 1991). Thus, assuming that the PPO Statute does come within the purview of the savings clause, the statute would create the anomalous situation that insured plans or plans with PPOs administered by insurance companies would be regulated, while self-funded plans administered by other third-party administrators would not.

It certainly seems unreasonable to maintain that merely establishing a PPO network is engaging in the business of insurance. *See Jordan*, 107 F.2d at 247. And the fact that an insurance company establishes such a program does not convert a non-insurance relationship into one involving the business of insurance. *See SEC v. National Securities, Inc.*, 393 U.S. at 459-60 (noting that insurance companies do many things that are not the "business of insurance").[9]

The PPO statute is essentially one-sided. It does not transfer or distribute risk from insured to insurer or vice-versa. It simply tells an insurance company that if it desires to satisfy its health care obligations through the use of a preferred provider network, then it must set nondiscriminatory terms and conditions for all potential providers. In short, this statute does not regulate the "business

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> insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

111 S.Ct. at 409.

[9] In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), the Court explained:

> The [McCarran-Ferguson Act] did not purport to make the states supreme in regulating all the activities of insurance *companies*; its language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.' Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply.

Id. at 459-60 (emphasis in original).

of insurance," and is thus not saved from preemption under ERISA.

CONCLUSION

Judgment will be entered for the Defendant. The Court is aware that, for good or bad, this decision means that Va. Code § 38.2-3407(B) is from this day forth unenforceable. However, in determining whether or not the PPO Statute is preempted by federal law, this effect is of no consequence. When federal preemption is invoked under the directive of the Supremacy Clause, it falls to this Court to examine the intent of Congress. By enacting ERISA, Congress explicitly mandated the preemption of state law as it relates to employee benefit plans, thereby displacing all state laws, even consistent ones, on the same subject. Thus, to the extent that this ruling creates a regulatory void in regards to preferred provider networks in Virginia, such a result is mandated by ERISA.

For the reasons stated above, the Defendant's Motion for Summary Judgment is granted.

Let the Clerk send a copy of this Memorandum Opinion and the accompany Order to all counsel of record.

7/22/92
DATE

/s/ Richard L. Williams
UNITED STATES DISTRICT JUDGE

APPENDIX D

STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144

(a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

McCarran-Ferguson Act, 15 U.S.C. § 1012

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Virginia Code § 38.2-3407

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

APPENDIX E

UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited

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[2] 15 U.S.C. § 41 *et seq.*

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); *Health Care Management Associates*, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition (1977).

panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these comments have addressed "any willing provider" requirements for health care service contracts.[6]

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[4] *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d. 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982); *Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital of Price George's County*, 110 F.T.C. 476 (1988); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988); *Medical Staff of Holy Cross Hospital*, No. C-3345 (consent order, Sept. 10, 1991); *Medical Staff of Broward General Medical Center*, No. C-3344 (consent order, Sept. 10, 1991); *see also American Society of Anesthesiologists*, 93 F.T.C. 101 (1979); *Sherman A. Hope, M.D.*, 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. *See, e.g.*, Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action, the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how provi-

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[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. § 33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

[9] Mont. Code Ann. § 33-22-1704(3).

ders and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10]

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[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. *See, e.g.*, J.C. Robinson and C.S. Phibbs, *An Evaluation of Medicaid Selective Contracting in California*, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. *See, e.g.*, D. Dranove et al., *Is hospital competition wasteful?* Rand J. Econ., Sum-

In addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to,

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mer 1992; *see also* G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that

opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirement may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs,

without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

/s/ Michael O. Wise
Michael O. Wise
Acting Director